

FILED DEC 15 1947
1949

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 5115

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: GENERAL HOSPITAL NO. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 DAYS
(Specify whether
In this community unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 128 MISSOURI
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

CHARLES GLENN

3. (b) If veteran, name war _____

3. (c) Social Security No. none

4. Sex MALE 5. Color or race NEGRO

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased JULY 12, 1880
(Month) (Day) (Year)

8. AGE: Years 67 Months 4 Days 22 If less than one day hr. _____ min.

9. Birthplace FORT SCOTT KANSAS
(City, town, or county) (State or foreign country)

10. Usual occupation CLERK

11. Industry or business HELPING HAND-128 MISSOURI

12. Name JOHN GLENN 13. Birthplace TENNESSEE
(City, town, or county) (State or foreign country)

14. Maiden name MARY JOHNSON

15. Birthplace VIRGINIA
(City, town, or county) (State or foreign country)

16. (a) Informant CHARLES GLENN (SELF)

(b) Address H.C. - no

17. (a) Removal (b) Date thereof Dec. 6 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City Cemetery

18. (a) Signature of funeral director Jerome McPherson

(b) Address 2503 1/2 Grand

19. (a) 12-5-47 (b) M. Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 14,
year 1947 hour 12:00 minute NOON M.

21. I hereby certify that I attended the deceased from NOVEMBER 12, 1947 to NOVEMBER 14, 1947,
that I last saw him alive on NOVEMBER 14, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death RESPIRATORY FAILURE Duration _____

Due to STATUS ASTHMATICUS

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 112 PHYSICIAN _____

Of autopsy _____ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at _____ (Specify type of place) (e) Means of injury 0

23. Signature [Signature] (M. D. or other) M.D.
Address GENERAL HOSPITAL NO. 2 Date signed 11/17/47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *DJ Manlove*
Licensed Embalmer No. 3994
P. O. Address 2503 Highley

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.